- Q: While an adult person's family is often not involved in his/her treatment process the family may provide a lot of support to that adult person. How will the adult person's family and other supporters be engaged under the new model?
 - A: ADHS/DBHS is developing a Technical Assistance Document (TAD) on Adult Clinical Teams which discusses the importance of involving all persons that provide services and supports to the adult person in the treatment process. Numerous questions concerning the involvement of family members and others are included in the assessment tool, thus assuring that the concerns of the family may be incorporated into the person's service plan.
- Q: How will the new process include the family, if the adult person does not consent to parent/family involvement?
 - A: The Clinical Liaison should provide oversight and assistance to a person's team on how to encourage the person to provide consent for the family member by explaining the benefits of family involvement. Even if consent is not ultimately given, the team is still able to listen to the concerns of the family members and others that are involved with the person without releasing confidential information.

Also, with regard to mental health information, A.R.S. § 36-509(A)(8) allows for information and records obtained in the course of evaluation, examination or treatment to be disclosed to family members actively participating in the person's care, treatment or supervision. An agency or non-agency treating professional may only release information related to the person's diagnosis, prognosis, need for hospitalization, anticipated length of stay, discharge plan, medication, medication side effects and short-term and long-term treatment goals.

ADHS/DBHS is currently in the process of developing a Technical Assistance Document (TAD) to assist with the clarification and interpretation of this law.

- Q: What are the changes to the SMI determination policy?
 - A: The ALFA has been replaced by the Global Assessment Functioning (GAF) scale. An SMI determination is conducted whenever the person/guardian requests a determination or when the person has a qualifying SMI diagnosis and a GAF score of 50 or lower. Other changes to the policy include a change in the timeline so that it now conforms to other program intake standards. The initial assessment meeting must occur within seven days of receiving the request and the written notice of determination must be provided within three days of this meeting if sufficient information if available.

For more detailed information please go to http://www.hs.state.az.us/bhs/policies/1-14.pdf, to review a copy of the SMI Determination Policy.

- Q: How does a person with a master's level degree who is not certified but wants to conduct assessments and service as a Clinical Liaison, become credentialed and privileged through the ADHS/DBHS process?
 - A: The Tribal/Regional Behavioral Health Authorities (T/RBHA) are responsible for ensuring that all individuals (both Behavioral Health Professionals (BHPs) and Behavioral Health Technicians (BHTs)) who are conducting assessment or serving as a Clinical Liaison are credentialed and privileged. The T/RBHAs may delegate this responsibility. In order to determine if a BHP or BHT has the required credentials the T/RBHA will obtain, verify and assess information related to licensure, education and/or work experience. (See ADHS/DBHS Provider Manual 3.20 Credentialing and Privileging for specific credentialing requirements.)

In order to be privileged to conduct assessments or serve as a Clinical Liaison, all BHPs will need to attend the eight-hour Strengths-based Behavioral Health Assessment Training. For BHPs who are currently conducting assessments or serving in the role of the Clinical Liaison the completion of the eight-hour Strengths-based Behavioral Health Assessment training must occur by June 30, 2004.

For BHTs to be privileged to conduct assessments or serve as a Clinical Liaison, they will need to attend the eight-hour Strengths-based Behavioral Health Assessment Training and an eight-hour Enhanced Assessment Training and have three assessments reviewed and approved by a BHP. Any BHT that is credentialed and privileged to conduct assessments or serve as the Clinical Liaison has to be supervised by a BHP.

- Q: Will the Clinical Liaison who performs the Core Assessment be required to meet with the person several times within the initial 45 day period allowed for completion of the assessment? Will the Clinical Liaison be required to be the person's ongoing therapist?
 - A: If the person requires care or support during the 45 day period between the intake and the completion of the assessment, the Clinical Liaison is responsible for ensuring that services and supports are delivered. In some instances the Clinical Liaison who performs the Core Assessment may continue to act as the Clinical Liaison for the person during this interval. In other instances the Clinical Liaison who performs the Core Assessment will be expected to serve as the point of contact for the person until the person is transferred to another Clinical Liaison who will continue to follow that person as they receive services that are addressed in the interim service plan. The Clinical Liaison who performs the Core Assessment will either conduct subsequent assessments in order to complete any applicable addenda that were not completed during the first appointment, or if the care is transferred to a new service provider, the new Clinical Liaison will be responsible for ensuring the assessment and all applicable addenda are completed with 45 days. The Clinical Liaison is not required to be the ongoing therapist for the person.

- Q: How does ADHS/DBHS define the "next service" following the Core Assessment?
 - A: The next service is any covered behavioral health service that is provided, including another assessment service, to the person following the initial Core Assessment. The next service must be provided within 23 days of this initial appointment.
- Q: How is ADHS/DBHS defining culturally competence and how does it apply to the assessment and service planning processes?
 - A: "Cultural competence is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age." (AHCCCS Policy)

In terms of the assessment and service planning process, cultural competency is viewed as an interviewing skill that lends itself to gathering cultural information that can result in a more comprehensive picture and understanding of the person/family and assist in the development of a service plan that is most relevant to the perceptions and values of a person. The assessor needs to understand how a person makes major life decisions and what internal and external factors influence those decisions. By recognizing that a person may be defined by a group in which they feel a part, be it a family, a religion, a socioeconomic group, an ethnicity, a sexual identify, etc., the assessor needs to explore how that group shapes the person's preferences, priorities and sense of the world. Not integrating a person's culture into the assessment and service planning process will seriously limit the clinician's likelihood of success in addressing the person/families needs.

- Q: What statements need to be asked to be culturally competent and how will ADHS/DBHS monitor that this is occurring?
 - A: As discussed above cultural competence is viewed as a skill that is applied throughout the assessment and service planning process. However, there are several questions in the assessment tool (see Core Assessment Presenting Problems the Strengths/Social/Cultural Addendum) that are designed to help the assessor understand the cultural preferences of the person and his/her family. The assessor and Clinical Liaison needs to ensure that the cultural preferences that are expressed are considered into the development of the service plan and ongoing services.
- Q: Please provide an example of how you would include cultural information into the service plan?
 - A: The service plan should be aligned with any cultural preferences that are expressed by the person and/or family. An example would be connecting the person with a particular service provider based on preferences that were identified through the assessment process

such as a provider located in particular neighborhood, a specific gender, ethnicity, age or with a special expertise.

- Q: Does the Annual Update involve redoing the initial assessment and does it only have to be done once a year?
 - A: While assessment and service planning is viewed as an ongoing process, the Annual Update records a historical description of the significant events and how the person/family responded to services provided during the past year. The Annual Update highlights the person's ongoing service needs, cultural preferences/considerations for service provision, current functioning and diagnostic information, risk factors, need for additional assessments or updates. Also as part of the "annual update" process, all demographic and clinical information for the person should be reviewed to ensure that the information is current. The Clinical Liaison or designee should complete the Annual Update with the person and other relevant participants present. This is the only assessment related form that will need to be completed on an annual basis. Any other forms that were submitted in the past (e.g., ALFA, SF12), are no longer are required. The Review of Progress which is part of the Service Plan document should be used to document the ongoing assessment process and evaluate the person's progress toward meeting his/her service planning goals.
- Q: Will service levels be assigned to persons?
 - A: Service levels are no longer a part of the new assessment and service planning process. Services provided to a person should be based on the individual needs of the person and his/her family not the service levels that are available. Each person should be assessed for the type and frequency of services needed, the supervision that may be needed to ensure engagement and the supports that also need to be available from the providers or family.
- Q: In regards to the timelines, is the 45 day period allowed to complete the assessment from the referral date or the intake date?
 - A: The provider has up to 45 days to complete the assessment from the initial intake date.
- Q: When will the new assessment and service planning tool be available to the public?
 - A: The assessment along with the addenda and service plan are now available on the ADHS/DBHS website. www.hs.state.az.us/bhs. A Spanish version is also available at the ADHS/DBHS Website.
- Q: Will this new assessment meet provider accreditation requirements (e.g., JCAHO)?
 - A: ADHS/DBHS took into consideration provider accreditation standards in designing the new assessment and service planning tools. However, providers are encouraged to confer with their accreditation organization as to whether the tool will meet all their

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requirements. Additional items may be added to satisfy JCAHO or CARF accreditation requirements; however the provider/RBHA must ensure that additional items do not substantially change the integrity of the ADHS/DBHS Assessment or add unnecessary burden to the assessment process.

- Q: If there are no addenda identified as needing to be completed during the first assessment but the need shows up later, can one add addenda at that time?
 - A: Yes, it is important to remember that assessment and service planning is an ongoing process that allows you to add addendums at any time.
- Q: Is the ALFA going to be eliminated, and will there be training on the GAF/CGAS?
 - A: The ALFA, CGI and SF 12 have been eliminated as a requirement of the assessment, effective July 1, 2003. Training on the new assessment and service planning tools will be provided to all clinicians who are going to be credentialed and privileged to conduct the assessment. This training will include discussion on the GAF/CGAS.
- Q: Who can determine a diagnosis?
 - A: Any Behavioral Health Professional (BHP) within his/her scope of work can determine a diagnosis. If a Behavioral Health Technician (BHT) completes the assessment, he/she can identify a preliminary diagnosis, however it must be confirmed by the BHP who is required to supervise and sign the assessment. At this time, only a psychologist or psychiatrist can make a final determination for SMI eligibility.
- Q: If a person drops out of treatment after a month or two and the service plan cannot be completed, how will this be viewed by auditors?
 - A: The interim service plan which is part of the Core Assessment must be completed at the initial appointment. This interim plan identifies the next steps and treatment recommendations for the person. The provider is then allowed up to 90 days from this initial appointment to complete the service plan. The provider should clearly document all efforts to engage or re-engage the person if he/she drops out of service prior to the completion of his/her service plan. If the interim service plan is completed and adequate efforts to engage or re-engage the person is documented an auditor would not find the provider out of compliance for an incomplete of the service plan.
- Q: Why does substance abuse have to be a triggered question when alcohol or other drug issues are often hidden, particularly with adolescents? Why is it not included in the additional addenda section? The same can be said for sexual abuse issues.
 - A: Substance abuse is a trigger question in the Core Assessment because it is so prevalent and often missed for persons seeking assistance for other problems. Substance abuse is not included in the additional addenda section, because it is comprehensively assessed as part of the Core Assessment. The same reasoning was used when developing the section

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related to sexual abuse issues. If additional information is revealed during the course of treatment, the core assessment items should be updated.

- Q: Will there be any change in the processes when a person is turning 18?
- A: The assessment process does not change the transition process for persons turning 18. While persons and their families need early preparation, the adult providers also need preparation for transition planning. An example of this would be for the person who will need a residential placement. The T/RBHA processes would need to be completed and a residential placement obtained, in time for the person's eighteenth birthday. ADHS/DBHS is developing a PIP that will outline the recommended procedures for transitions. When it has been finalized, it will appear on the ADHS/DBHS website.
- Q: Are providers required to call persons to offer them appointments for written referrals? When does the clock start for determining timeliness of the initial assessment appointment? How should providers document these attempts?
 - A: Providers are required to call persons to offer appointments for all forms of referrals, including written referrals, based on the urgency /clinical need of the person and in accordance with ADHS/DBHS Policy 1. 9 Timeliness of Service. An appointment for the initial assessment must be made available to the person within seven days of receipt of any referral. The clock starts as soon as the referral is received by the T/RBHA. All attempts to schedule the initial appointment upon receipt of the referral should be documented in the referral log.

For more detailed information, please go to: http://www.hs.state.az.us/bhs/policies/1-4.pdf to review a copy of the referral process policy.

- Q: Does a provider need to collect financial information (e.g., household income) on all persons who request behavioral health services?
 - A: Information on gross family income and family household size must always be collected from non-Title XIX/XXI eligible persons in order to determine the co-payment amount to be charged to the person for any covered behavioral health services provided. Information on family income would only need to be collected from a Title XIX/XXI eligible person in those limited circumstances when a co-payment may be collected (e.g., room and board in a Level I or II behavioral health facility). See the ADHS/DBHS Provider Manual 3.2 Co-payments for more detailed information.
- Q: How often does demographic data need to be submitted to ADHS/DBHS and will this information be used to measure outcomes?
 - A: The T/RBHAs are required to submit the demographic data set to ADHS/DBHS no later than 45 days after intake and to re-submit a select set of demographic data fields when there is a significant change in the person's condition, after completion of the annual update or at the time of disenrollment. The following data fields will be used as outcome

indicators: employment status, educational status, primary residence, Axis I, II and V (GAF), number of arrests and primary and secondary substance use. See the ADHS/DBHS Demographic Data Set Definitions for more detailed information.

Q: Is there still a requirement to complete a separate Strengths and Cultural Discovery (narrative) for children in addition to the Family and Community Addenda?

A: At this point DBHS requires that the Assigned Clinician complete the Strengths and Cultural Discovery (narrative) in conjunction with the "Family and Community" addendum, which serves as a basis for initial responses during the assessment. DBHS recognizes that a Strengths and Culture Discovery may go beyond the questions asked in the "Family and Community" Addendum and would expect to see a reflection of these additional discussions in a formal Strengths and Culture Discovery document. ADHS/DBHS is currently developing a PIP that will describe the Cultural Strengths Discovery process in detail. When it has been finalized, it will appear on the ADHS/DBHS website.

Q: Do SMI plans need to be completed at 6 months or just annually?

A: SMI rules require that a SMI service plan must be reviewed at a minimum of every six months. It is more likely that it will be reviewed each time the member is seen by their prescriber. Although there is no statement that requires that it be updated (it could remain the same), charts need to show documentation of the review. It is suggested that the Behavioral Health Service Plan Review form be used to demonstrate the review of these plans.

Q: Clarification is needed on exactly what needs to be completed for Service Plans.

A: The Service Plan is a 2-page document. The front is the Service Plan "proper" and the back is the Behavioral Health Service Plan Review. The Service Plan proper is used alone during the first time that it is completed. Whenever circumstances change, the Service Plan proper is modified and the Behavioral Health Service Plan Review is also completed and serves as a narrative, which describes the reasons for the changes. The Annual Behavioral Health Update and Review Summary is done on a yearly basis and reviews all of the progress which has been made with the member from the time of his/her Comprehensive Assessment or last Annual Behavioral Health Update and Review. A signature block will be added to this document for the member to sign and date.

Q: BHT requirements (AA or equivalent coursework). Some people might have experience and be working towards their bachelor's degree but not actually have an AA degree. Can these people become a Clinical Liaison?

A: BHT's are required to have a minimum of an AA degree that includes required behavioral health course work and who have work experience as required by DBHS and completed the assigned trainings (Strengths-Based Behavioral Health Assessment

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Training & Enhanced Assessment Training) to be credential and privilege to become an Assigned Clinician.